AmeriHealth NEW JERSEY

Please Mail To:
Claims Processing Center
PO Box 211184
Eagan, MN 55121

Handicap Child Claim Form (see reverse side for instructions)

MEMBER INFORMATION		
Member's Name (First, Middle, Last)	Identification No.	
Present Address-Street	City, State	Zip Code
Employer's Name (First, Middle, Last)		
Employer's Address-Street	City, State	Zip Code
I HEREBY APPLY FOR CONTINUATION OF COVERAGE FOR THE FOLLOWING CHILD UNDER MY SUBSCRIPTION AGREEMENT(S):		
Name of Dependent (First, Middle, Last)	Birthdate	
Realtionship to Member	Is Dependent Married? ☐ No ☐ Yes	

Is the dependent:
a. Receiving benefits ☐ No ☐ Yes
b. Covered by Medicare ☐ No ☐ Yes
c. Receiving Social Security benefits ☐ No ☐ Yes
(If yes, please attach copy of "Notice of Award" or most recent notice of benefit changes)

Is dependent currently covered as a handicap/disabled dependent by another carrier? ☐ No ☐ Yes
(If yes provide carrier name and ID number):_____

Why are you applying for continuation of benefits for the dependent at this time?
_____

Can dependent perform Activities of Daily Living (i.e. bathing, dressing, eating)? ☐ No ☐ Yes

Can dependent travel to and from a destination unattended? ☐ No ☐ Yes

Does dependent work for wages? ☐ No ☐ Yes

What are the specific ways in which you support / assist the dependent:
_____
_____

If your dependent is presently enrolled under his/her own AmeriHealth Agreement, give:
ID No.:_____
Group Plan No.:_____
Location:_____

I hereby certify that the above child is unmarried, is incapable of self-support, is dependent upon me for more than half of his or her support and that his or her disability commenced prior to age 19.

I understand and agree as follows: That the requested coverage for the above child shall not become effective unless and until this application is accepted and approved by AmeriHealth and thereafter may be revoked by AmeriHealth if any of the statements made herin are incorrect or if AmeriHealth later determines that the above dependent no longer qualifies for coverage as a handicapped dependent; that this application will become a part of my original application and will be subject to the terms of my subscription agreement(s); and; that acceptance of this application does not confer eligibility upon the above child for Major Medical benefits unless the group agreement describing the Major Medical program so stipulates.

I further understand and agree that AmeriHealth reserves the right to request additional documentation if required.

Signature:_____ **Date:** _____

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Instructions

Note: Any fee for the completion of this form is the responsibility of the member.		
Physician's name:	Degree/Specialty:	
Present Address-Street	City, State	Zip Code
Phone Number:		

1. The noted patient is presently under my care ☐ No ☐ Yes

2. Date dependent was last treated: _____

3. Diagnosis and concurrent conditions resulting in disability: _____
   If mentally impaired, define mental impairment in terms of mental age _____, **IQ** _____, **or functional capacity in work, educational, or social setting** _____
   If physically impaired, define physical impairment in terms of capacity to perform activities normally performed by individuals of comparable age, intellectual capacity _____
   Is condition temporary or permanent _____ static or progressive _____

4. Has such disability existed continuously since before dependent attained age 19? ☐ No ☐ Yes

5. Has dependent been confined in a hospital as a result of this disability? ☐ No ☐ Yes
   If yes, give name and address of hospital: _____
   Date admitted: _____ Date released: _____

6. Current treatment:
   A. Medication – i.e. dosage, frequency _____
   B. Care plan _____
   C. Compliance with prescribed treatment ☐ Good ☐ Fair ☐ Poor
   D. Currently controlled with medical management? ☐ No ☐ Yes (If no, why not _____
)
   E. Goals/Expected Outcome _____

7. Prognosis:
   Is dependent totally disabled? ☐ No ☐ Yes
   Is dependent capable of self-support? ☐ No ☐ Yes
   Do you expect a fundamental or marked change in the dependent's condition in the future? ☐ No ☐ Yes
   If yes, when will the patient recover sufficiently to be capable of self support? _____
   If no, please explain: _____

8. Additional remarks: _____

Signature: _____ **Date:** _____

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Language Taglines and Nondiscrimination Notice

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

(OVER)

Language Taglines and Nondiscrimination Notice

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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